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ABSTRACT

In June 1999, Making the Grade and the National Assembly on School-Based Health Care sponsored a workshop to examine the best political and financial strategies for fostering the growth and stability of school-based health centers (SBHCs). State and local elected officials offered detailed accounts of how public support for a growing network of centers has been built in their localities. Public officials as well as private representatives from several hospital and health care systems discussed their successes and failures in designing funding strategies to sustain centers for the long term. This paper, inspired by and based in large part on the workshop proceedings, examines the political and funding strategies that have laid a foundation for continued expansion of the centers. (Author/EV)

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FROM THE MARGINS TO THE MAINSTREAM:

A MAKING THE GRADE MONOGRAPH

Institutionalizing School-Based Health Centers

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Occasional Papers on Policies Affecting School-Based Health Centers Summer 2000

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From the Margins to the Mainstream:

Institutionalizing School-Based Health Centers

A Making the Grade Monograph

Jane Koppelman
Julia Graham Lear

June 2000

Making the Grade: State and Local Partnerships to Establish School-Based Health Centers, The George Washington University School of Public Health and Health Services, 1350 Connecticut Avenue, NW, #505, Washington, DC 20036. www/gwu.edu/~mtg

From the Margins to the Mainstream: Institutionalizing School-Based Health Centers

In June, 1999, Making the Grade and the National Assembly on School-Based Health Care sponsored a workshop to examine the political and financial strategies that have best fostered the growth and stability of school-based health centers. State and local elected officials offered detailed accounts of how public support for a growing network of centers has been built in their localities. Public officials as well as private representatives from several hospital and health care systems discussed their successes and failures in designing funding strategies to sustain centers for the long term. This paper, inspired by and based in large part on the workshop proceedings, examines the political and funding strategies that have laid a foundation for continued expansion of the centers.

Introduction

Fifteen years ago, the notion of making health services more accessible to children by placing them in schools was a revolutionary idea known only to a handful of people. In 1985, with no more than 50 school-based health centers across the country, it was an intriguing but fragile concept.

Today, more than 1,200 centers are found in 45 states and the District of Columbia. Thirty-six states provide grant support.[1] Forty-three states permit school-based health centers to bill Medicaid for patient care, and centers in twenty-two states are providers in Medicaid managed care networks. These developments mark the transition of school-based health centers from the margins to the mainstream of the American health care system.

School-based health centers were originally launched to address the very low health care utilization rates of school-aged children, and the reality that adolescents (11-19 year-olds) are the least likely of any age group to have health insurance or to seek health care at a provider's office, even when insured. The centers were also designed to identify and offer counseling to troubled children; risky behaviors (e.g. smoking, substance abuse, motor vehicle accidents, unprotected sex, and violence) account for 70 percent of the morbidity and mortality of school-aged children.

As more centers have opened and have been sought out by schools, leaders in the field have wrestled with two challenges: learning how to gain the support of elected officials and identifying the most dependable financial strategies for long-term growth. Large-scale replication hinges on successfully addressing both these challenges.

Three States Build Political Support for School-Based Health Centers

Organizing a political voice for school-based health centers has had its challenges. Because centers involve a variety of health professionals and are sponsored by a mix of institutions (hospitals, health departments, and community health centers, among others), they are somewhat of a political orphan. No single professional association or employee union feels obligated to represent the interests of centers before lawmakers.

Moreover, centers have found it challenging—especially at the federal level—to market themselves with a simple and succinct mission statement, because they serve different purposes in different communities. Some are designed as a medical home for uninsured children; a secondary access point for insured children; a means for increasing high school graduation rates; a confidential place to address adolescents' issues; or some combination of the above. Thus, advocating for them in the political process has been difficult.

Despite these challenges, Louisiana, Connecticut, and Delaware are among a number of states that have developed the advocacy and legislative support that has led to increased state investment in school-based health centers. Grass roots advocacy played a major role in building legislative support for centers in Louisiana. In Connecticut, key legislators and state public health officials are largely responsible for state grant funding and for assuring access to Medicaid managed care revenues. Delaware's support for school-based health centers in all but one of the state's twenty-nine high schools suggests the benefits of strong gubernatorial leadership and good timing.

Building Support in a Conservative State: The Louisiana Experience

Between 1992 and 1998, school-based health centers in Louisiana grew from eight to thirty-five. During that time, their chief source of support shifted from The Robert Wood Johnson Foundation and the Maternal and Child Health (MCH) block grant, to state general fund dollars, which in 1998 exceeded $4 million. "Real growth in funding for school-based health centers has come during the past four years under a relatively conservative Republican governor with legislative Democratic and Republican teamwork," said Jay Dardenne (R), Senate Majority Leader and leading health center advocate.

The story of how the legislature first approved general revenue funding for school-based health centers involves timing, luck, and a growing grass roots advocacy effort. Since 1992 the state had funded centers with MCH block grant moneys to address adolescent morbidity rates as well as their low use of health care services. In 1995, Democratic Governor Edwin Edwards was promoting a gambling initiative and wanted to use some of the state's video poker profits to fund crime and violence prevention programs.

A variety of child advocates lobbied for the money. What seized the attention of the legislature was the testimony of a 15-year-old boy who stated that the anger management program in his school-based health center had kept him from shooting his mother's abusive boyfriend. The one-time gambling revenues were allocated to school-based health centers.

Real growth in funding for school-based health centers has come during the past four years under a relatively conservative Republican governor with legislative Democratic and Republican teamwork.

Jay Dardenne
Senate Majority Leader
Louisiana Senate

"Once we had our foot in the door we kept building on that," recalled Sylvia Sterne, Director of Adolescent Health for the Louisiana State Health Department. "It enabled us to create more centers, build more constituencies, have more legislators understand what we were doing and how important it was, and we eventually got into the line-item recurring budget."

Four other factors conspired to persuade the legislature—led by conservative Republicans—to create the permanent budget line-item.

First, a compelling need for basic medical services for youth helped overcome the political controversy surrounding the centers. The absence of medical care in rural areas, a thirty-two percent poverty rate among Louisiana children, and a twenty-one percent uninsurance rate helped to mute arguments that services were duplicative, or, as the Christian Coalition argued, that centers were established primarily to address teen sexuality issues.

"The mission of our program from the beginning was to provide access to health care to the most needy children," said Sterne. "Adolescents had almost nowhere to go for health care. Our statistics on morbidity and mortality of adolescents were out of control," she added. "In Louisiana, school-based health centers exist in schools where most children are eligible for the free or reduced-price lunch program, and are the only primary health care provider for most of the population they serve," she noted.

In addition, legislators were concerned about the state's illiteracy and high school drop-out rates. Finally, they also wanted to reduce the growing hospital charity-care budget, which was stressing state finances. Charity-care costs were rising because an underdeveloped primary care network led to overuse of emergency room care.

"Even conservative legislators looking to save money in Medicaid budgets and public health budgets recognize that if we can deliver more targeted primary services at a school-based clinic, that's a better use of tax dollars," said Dardenne. "We have been able to make it clear that these are desperately needed services that are being provided, and we make that all-important link between health and education, which I think is the key here. If we can keep kids healthy, and [keep] them in school we have a better chance of their being successful in life," he noted.

From the beginning, building community support for school-based health centers has been fundamental to the state's grant program. "At the local level, we built in the fact that if [centers] wanted to gain support, they would have to do some grass roots organizing," Sterne said. The Louisiana health department requires evidence that local people approve plans for school-based health centers and that official applications for funds are approved by local school boards.

Once grants were approved, the health department encouraged center staff to meet with parents and students, hold press conferences, host open houses, and invite elected officials to tour centers. Senator Dardenne was introduced to school-based health centers when a center in Baton Rouge, where his wife volunteered, invited him to visit.

In a critical move that has been essential to bipartisan legislative support for the centers, health center advocates chose not to oppose a 1991 state law which prohibits referral and counseling for abortion and the dispensing of contraceptives on school grounds.[2] Local restrictions on the provision of reproductive health services were also accepted.[3] Some communities prohibit centers from testing and treating for sexually transmitted diseases, and some do not allow pelvic examinations for sexually active girls.[4] Centers addressed concerns raised by the Christian Coalition by inviting public officials and the media to observe their practices and confirm that they were complying with state law.

Senator Dardenne cautions that if national leaders of the school-based health center movement insist on the inclusion of reproductive health care in all centers, they risk hurting the centers' expansion in Louisiana and other conservative states. He acknowledges that some conservatives will probably always oppose the health centers, "but the more firmly entrenched the funding becomes, the more difficult it is going to be to uproot it."

State Grant Funding and Medicaid Managed Care Participation: Connecticut's Dual Strategy

With a state grant of $50,000 to establish the state's first center in 1985, Connecticut was one of the earliest states to support school-based health centers. By 1998 there were fifty-one centers and during 2000, that number is expected to climb to fifty-seven. While private foundation funding contributed to this expansion, as in Louisiana, the greatest engine of growth has been state general funds that currently total $5.7 million.

In the mid 1990s Connecticut began to see Medicaid managed care as a way to supplement state grant funding for centers, and has been one of the few states to require that centers be managed care providers. Today more than 80 percent of all school-based health centers in Connecticut have Medicaid managed care contracts.

Grant Support. State grant support for centers has been a bipartisan effort. Funding began under a Democratic administration, continued with strong support from an Independent governor, and has retained its support through a Republican

administration. A general decline in state funding for grant programs slowed expansion of the centers in the mid-to-late 1990s. At the end of the decade, however, center growth resumed.

William Dyson, a Democratic Assemblyman who chairs the state House Appropriations Committee, has been key to legislative support for centers. Mr. Dyson teaches history in a high school that houses a school-based health center, and has experienced its benefits to students. He offered the following suggestions to centers seeking to inform legislators about their work:

- *Know who is in charge politically.* Identify the chairs of the appropriations and other committees with jurisdiction over school health. Find out the issue interests of these members and which members they partner with when trying to move a bill.

- *Practice coalition politics.* Understand the horse-trading that occurs to get legislation passed; know which legislators are siding with each other and which are in the position to trade favors; and make sure they are all at least informed about school-based health centers.

- *Do not assess a member's political stance based on his or her color, gender, or political party affiliation.* "Just because a group is all women does not mean they're toeing the same line, and just because a group is Republican doesn't mean they are all toeing the same line. I have Republicans I can rely on quicker than I can some Democrats on my side," he commented. "You've got to go to each one individually and find out where they are, what their interests are, those things they believe in, and build the coalition based upon that."

- *Be prepared to substantiate your claims.* "Legislators," he noted, "are pelted by competing requests for money from various interest groups. It is important to back your arguments with information that substantiates the need for or value of supporting the request." As an example, Mr. Dyson pointed to the predicament of advocates who lobbied fiercely for the 1997 State Child Health Insurance Program (SCHIP) based on high rates of uninsured children, and by 1999 were finding that states were not spending their allotments because of slow enrollment in the program. "Those advocates on that issue need to understand that [their] credibility just got shot with me, because you made the case for what the needs were, that the people were out there, but somehow you didn't find them after you said they were there."

- *Get more men involved.* "The political reality is that the more men representing a political issue, the more consideration the issue gets," he warned. "School-based health centers are in danger of marginalizing their cause because they lack gender diversity."

There's nothing that has a greater effect on influencing what takes place [in the state legislature] than the ground-swell of a group that appears to be together and unanimous in what they want to do.

William Dyson, Chair
House Appropriations Committee
Connecticut Assembly

Dyson emphasized the importance of mobilizing community members to contact their legislators. "A loud grassroots political voice can be effective even when a movement lacks the money for sophisticated professional lobbyists," he said. "There's nothing that has a greater effect on influencing what takes place than the groundswell of a group that appears to be together and unanimous in what they want to do."

Medicaid Managed Care Participation. Connecticut is also one of a handful of states whose Medicaid agency has taken major steps to include school-based health centers as providers in Medicaid managed care networks. In 1995, when state Medicaid officials were designing their managed care program, they decided to require participating health plans to include centers in their provider networks. "The [schools] make a logical point [for us] to have those primary contacts to deliver preventive services, because in our program, just as in many programs, the largest percentage of our eligibles are children," noted former Connecticut Medicaid director David Parrella.

Because the Medicaid agency focused on closing access gaps in all parts of the state, Parrella said their service delivery system would have been incomplete using only private providers, due to the dearth of private providers—especially dentists—serving Connecticut's low-income communities.

State health officials actively encouraged dialogue between the centers and plans by convening meetings when discussions between the two parties had stalled. They also displayed their willingness to enforce the contract requirement. The State Department of Social Services threatened to close off Medicaid enrollment for three plans until they signed contracts with centers. The Department of Public Health threatened to let expire contracts with three health center sponsors for failing to negotiate with plans. Their intervention has been responsible for the high portion of centers that have negotiated Medicaid managed care contracts.

A Governor at the Helm of School-Based Health Center Expansion: The Delaware Experience

Delaware is the only state with nearly universal access to school-based health centers for high school students; all but one of the state's twenty-nine high schools houses a center.

While centers in most other states piece together funding from state and local sources, private foundations and third-party billing, Delaware's centers are almost exclusively funded with state general revenues. State funds totaled nearly $5 million in school year 1999-00.[5]

Since 1985, the public health department has promoted school-based health centers as a means of improving access to care for adolescents. While the proportion of uninsured children in Delaware has hovered at or below the national average for over ten years, adolescents were not receiving care, according to Nancy Bearss, veteran school-based health center nurse practitioner and advocate.

Rapid expansion of the centers began in the early 1990s and was driven by two factors. In 1993, a new governor, Democrat Tom Carper, took office. Earlier in his career as a congressman, he had visited a school-based health center and was captivated by the model. Also during 1993, Delaware's high infant mortality rate became widely known and a cause of political concern. A commission established to study the problem recommended school-based health centers as a means of reducing infant mortality by way of lowering teen pregnancy rates. The governor placed centers high on his agenda.

Interestingly, when the state education and health departments developed a memorandum of agreement to guide the new centers, the centers were prohibited from either dispensing or prescribing contraceptives.

In his first term, Carper announced his goal to place a school-based health center in every public high school that wanted one, according to Lynn Howard, aide to Governor Carper.[6] "This was an idea that just made sense," Carper noted in an interview.[7] "When I ran for governor, the focus of my campaign was on strengthening families. Promoting school-based health centers tied in well with that theme," he said.

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> Governor Tom Carper
> State of Delaware

School-based health centers could serve adolescents who need "access to a variety of kinds of care, including mental health, nutrition, counseling [regarding] abuse at home, eating disorders, pregnancy tests, [and care for] STDs. [Students] could access them through school," he said. Carper described the legislature's support for school-based health centers as "incremental." "Each year we funded a few more . . . we didn't push them down anyone's throat."

Will centers fare as well when Governor Carper leaves office in January 2001? "It won't make any difference," said Republican state representative Nancy Wagner. "These things transcend governors. We support them and we want them." Wagner, who praised the centers' ability to respond to adolescent depression, eating

disorders, and other behavioral problems, believes that the number of school-based health centers in Delaware would have increased without Carper's involvement. Because of the state's small size, news of a successful program travels by word of mouth, she noted. "When you see something that's making a difference and it's working, you want to copy it."[8]

Financing Strategies Considered and Reconsidered

As political support leads to more funds for school-based health centers, the challenge remains to identify the best, most reliable sources of public support. Today the leading sources are state general revenues, the federal/state MCH block grant, and, in some locales, city and county money. Third party payers, especially Medicaid, are viewed by some as an important source but one made uncertain by the spread of managed care. The following paragraphs highlight the views of a range of health care officials in describing the pros and cons of a number of these financing approaches.

State General Revenues

State interest in funding school-based health centers began to grow in the early 1990s and has now supplanted private foundation and MCH block grant funding as the single largest source of support for centers. In 1998, twenty-two states contributed over $28 million in state revenue to support centers, so that an estimated 650, or over half of all school-based health centers, received some state general revenue funding. [9]

One of the strengths of funding centers through a state budget line-item is that it creates a permanent authorization for the program in the state budget, making it much harder to eliminate than a program whose funding must be fought for every year. State grants, when large enough—as in the case of Delaware—spare school-based health center administrators the time-consuming task of fundraising. In addition, general grant funds encourage centers to offer services according to need rather than the particulars of what insurance plans or categorical grants will support.

One of the vulnerabilities of relying on this funding source is that its continuation usually rests on the strength of organized advocacy. Colleen Seyburt, a former public health official from Arizona, speculated that the absence of organized advocacy by centers in her state has weakened their chances of tapping into Arizona's second round of tobacco tax funding. In 1995, the state allocated $3.5 million of tobacco tax funds to support primary care services, including those offered in school-based health centers. As a result, the number of centers increased from thirty-three to nearly eighty-five by the late 1990s. However, the state will invite proposals in 2000 for tobacco tax funding and Seyburt anticipates there will be many more competitors for limited funds.

Generally, state support is too limited for school-based health centers to rely on exclusively. But some believe the need to secure multiple funding sources can serve to strengthen centers. For example, soliciting local dollars encourages centers to

build networks and support at the community level. Centers that pursue third- party revenues will also have a financial incentive to maximize productivity. As a related benefit, the ongoing need to seek funding may spur centers to document their program quality as a means of attracting potential funders.

Third-Party Revenues

Insurance payments from Medicaid, commercial plans, and the State Child Health Insurance Program (SCHIP) have been a small, but growing revenue stream for school-based health centers. Public and private insurance payments, while often difficult to collect, are an increasingly attractive source of support for two reasons. First, enrolling eligible children in SCHIP and Medicaid has been a major national focus targeted on the very population of children that school-based health centers serve. Also, although thirty-six states fund school-based health centers, only Delaware provides enough money to sustain the centers with little additional support. In all other states, other sources of funding are essential.

For now, Medicaid is the largest third-party revenue source for school-based health centers. Revenues from the new SCHIP program, designed to cover children of the working poor, may well increase but currently are meager because the program is new. Private insurance collections have been small because most centers are located in low-income communities. In a survey of the 1998-99 school year, thirty-eight of forty-four Making the Grade school-based health centers reported that private insurance represented about twenty-eight percent of all charges billed and fourteen percent of revenues collected.[10]

In the early-to-mid 1990s, centers began to bill insurance in large numbers. While insurance payments have contributed modestly to the centers, revenues from billing are often found to increase with experience. For example, while Medicaid revenues, on average, represented under ten percent of operating costs for school-based health centers in the mid 1990s, some centers have reported collecting between twenty-five percent to sixty percent of operating costs from Medicaid.[11]

The Challenge of Managed Care. During the 1990s, just as centers were gaining steam and generating more income from billing insurance, the rules of third-party billing began to change. Managed care surpassed fee-for-service as the dominant insurance model for both Medicaid and the commercial market. By 1998 an estimated fifty-two percent of Medicaid children were enrolled in managed care, as were about sixty-three percent of children with private insurance.

As a result of these billing changes, a number of centers reported losses in third party revenues, especially in Medicaid, their largest insurance source. In short, managed care has made it harder for centers to participate in Medicaid. Under fee-for-service, centers were required only to meet state provider qualifications in order to bill Medicaid directly for patient care. Under managed care, state Medicaid agencies no longer pay providers directly; they pay health plans to organize pools of providers to serve enrollees. In most states with Medicaid managed care, contracting health plans are not required to include centers as providers, even if they meet the states' provider qualifications. Persuading health plans of the value of using centers

as providers becomes essential. But the pitch is often not successful, given the disincentive that capitation places on either, or both, the health plan and its network of providers to share payments.

Centers that wish to bill SCHIP managed care and commercial managed care plans face the same challenges in joining provider networks.

Pros and Cons of Billing Insurance. The advantages of school-based health centers' billing Medicaid, commercial insurers, and SCHIP for patient care are numerous. A desire to generate more income through billing can influence a center's behavior in the same way it does a private practice. Centers can be motivated to increase productivity and focus more acutely on practices that raise the quality of care and patient satisfaction. Moreover, those centers participating in managed care networks will be required to deliver care in a way that reinforces quality by, for example, having to adhere to credentialing requirements and the rigorous documentation of care.

Centers also report that billing insurers, or in the case of managed care, seeking preauthorization for care from health plans, is a process that is complex, and too time-consuming for their small staffs. Billing, whether through fee-for-service or managed care, also means that centers must ensure that plans avoid sending statements for sensitive services home to parents, so that these services remain confidential.

Finally, it is important to note that centers cannot survive exclusively on third-party revenues because they offer an array of services that are not covered through the typical public or private benefit package. Non-billable services may include: individual and group counseling for children without psychiatric diagnoses; case management to ensure care is coordinated with a child's primary care provider; parent communication; nutrition counseling; behavioral risk screening; consultation with teachers, special education teams, school counseling staff; and classroom health education.

Institutional Sponsorship

School-based health centers almost never operate autonomously. Nearly all have institutional sponsors that use their human and financial resources to sustain the centers. As centers have developed in communities that do not benefit from Delaware-size grants, the role of sponsors in securing funds, building political support, and negotiating agreements with school systems or health plans has become critical to the viability of centers. A recent survey documented that hospitals, which sponsor 30 percent of all school-based health centers, have become their single most important institutional base.[12]

A number of representatives from hospitals and health systems have spoken about why their organizations decided to sponsor school-based health centers, as well as how they have managed to fund centers over the years. While their experiences are

particular to their institutions, they suggest why and how other entities (community health centers, public health agencies, and schools) may become engaged in organizing centers.

The Hospital Experience. For most hospitals, sponsoring a school-based health center is not a profit-generating venture. Hospital sponsors report a number of benefits that, they say, make centers worth the investment. "The hospital gets a lot of mileage out of having a relationship with the schools," said Linda Therrien, Director of Community Health Programs for The Children's Hospital of Denver. "A lot of it is their image in the community."

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> Hospital, Denver

Community image is a benefit many hospital sponsors point to. "We provide comprehensive care, and it's care that the community keeps telling the school system and our hospital district members that they like," said Anne Platt, official with the Broward County Hospital District, which sponsors eight school-based health centers that also serve the larger community after school hours.

Some hospital representatives also view school-based health centers as a way to increase market share, attract private donations and help nonprofit hospitals meet community service obligations required by their federal tax-exempt status. Guidance issued by the Internal Revenue Service in 1992 requires nonprofit hospitals to demonstrate that they are "involved in projects and programs which improve the health of the community" to remain tax exempt.[13] However, in many communities, school-based health centers are among a number of projects competing for hospitals' community service support.

Other hospitals may respond to evidence that centers can reduce emergency room use among patients.[14] The most recent study to confirm this finding found that teen members of Kaiser Permanente of Colorado who had access to school-based health centers in Denver had thirty-eight percent to fifty-five percent fewer after-hours urgent visits per year than did their peers without school-based health center access.[15]

To date, the most compelling reasons for hospital sponsorship of school-based health centers come from those hospitals with explicit missions to serve the poor. For example, the Denver Health and Hospital Authority (DHHA), which sponsors 12 school-based health centers, receives state funds to serve uninsured and low-income persons. "There is a state medical indigent fund that pays for services to uninsured residents of the state of Colorado, and we have money that comes into

our institution for providing those services to indigent individuals, and some of those individuals get services in our school-based health centers," said Paul Melinkovich, M.D., director of DHHA's school-based health center program.

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> Director, School-Based Health Centers
> Denver Health & Hospitals

Melinkovich explained why his organization, a network that also includes a public hospital and community health centers, decided to invest in school-based health centers. "If you looked at the utilization of our community health centers that have been in existence for... more than thirty years, our penetration into the school-aged and adolescent population was quite low. We saw kids up to about five years of age, and after that time period didn't see them again until they were about sixteen or seventeen, and the biggest reason we saw them at sixteen or seventeen was pregnancy. Philosophically, if you wanted to be able to reach the population early, and intervene early, school-based health centers made sense. "And," he noted, they were a "less expensive alternative to serving kids than our community health centers."

The Broward County Hospital District has the same mission. "Our hospital district is tax assisted, so therefore we have the responsibility for indigent care in the community," said Platt. "Our hospital district looked at [school-based health centers] as a cost-effective, efficient way of providing enhanced services into the communities for children and families that were underserved."

"We keep trying to get money from outside and nobody gives it to us. So, the result of that has been that we've had to devise strong measures within our community and alliances and collaborations in order to fund ourselves." The results of this bootstrap effort are impressive. From 1991 through 1998, the North and South Broward Hospital Districts raised $9 million in state and local funding for the eight centers.

Strengths and Weaknesses of Institutional Sponsorship. Institutional sponsorship can bring a number of advantages to school-based health centers. Center operations can often improve if they have access to the management and financial systems of their sponsors. Advantages may also accrue if sponsors use their political and financial power to promote school-based health centers among lawmakers. Children's Hospital of Denver, for example, has agreed to use its state lobbyist on behalf of school-based health centers.

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Ann Platt, Director
School Health Programs
North Broward Hospital District
Florida

When hospitals, in particular, are sponsors, centers may be able improve continuity of care because hospitals can make their specialty clinics, laboratory, and radiology services available to students who need more complex care. Also, hospital sponsorship encourages policymakers to view the health centers as part of the mainstream health care delivery system, a perception that enhances the centers' survival.

Like other funding strategies, institutional sponsorship has its limitations. For instance, the primary focus of the institution may bias the care provided by centers in particular directions. Hospitals, because of their strong clinical base, may tend to neglect health promotion and prevention programming. Sponsors that lack mental health expertise may neglect this critical aspect of the centers' service package. Perhaps the largest drawback of relying on funding directed through the institutional sponsor is that school-based health centers may be one of the first items to be cut during lean financial times. When budgets get tight, the centers may not be viewed as part of the core mission of a hospital, a community health center or a public health department.

Conclusion

The melding of primary care, mental health and health education in one location within a school building has proven a powerful model for addressing the health needs of children, but a challenging model around which to build strong political support or a simple funding design.

Despite these challenges, school-based health centers have continued to grow and gain status within the mainstream health care delivery system. State by state, funding for centers is rising incrementally. In the spring of 2000, for example, New York approved an additional $7 million for school-based health centers, bringing total state funding to $17 million; and Massachusetts voted an addition $5 million that will increase state funding for centers to $7 million.

Experience from states that have supported center expansion suggests that large-scale replication cannot be achieved without strong political advocacy. Louisiana has demonstrated that such support can be built even when advocates start out without much money or political influence. As Connecticut Assemblyman William Dyson noted, "There's nothing that has a greater effect on influencing what takes place in the state legislature than the groundswell of a group that appears to be together and unanimous in what they want to do."

Strong public support will open the door to the more technical discussions regarding how to design a funding strategy that will best support school-based health centers for the long term. For instance, greater political support may create pressure for insurers to cover more benefits provided by centers. It may also lead health plans to more readily include centers as providers in their networks. At the same time, creating easily accessible funding sources for centers may lead more communities to establish them. Such growth would naturally expand the base of political support for centers.

In sum, public support appears essential to replication. There will be no easy technical fixes and no sure-fire third-party reimbursement schemes. Rather, the centers will need to continue building public understanding and political interest in their ability to help the nation achieve its goals for healthier children and youth. This challenge will require centers to redouble their commitment to increasing their visibility and documenting their successes as they work towards these goals.

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[1] Lear, J.G., N. Eichner and J. Koppelman. "The Growth of School-Based Health Centers and the Role of State Policies: Results of a National Survey." Archives of Pediatrics & Adolescent Medicine 153 (November, 1999):1177-1180.

[2] ACT 1055, House Bill No. 169L. Signed by Governor Buddy Romer on July 29, 1991.

[3] Louisiana Department of Health and Hospitals Office of Public Health, "Principles, Standards and Guidelines for School-Based Health Centers in Louisiana," p.1.

[4] Sylvia Sterne, Director, Adolescent and School Health, Louisiana Office of Public Health, telephone interview conducted by Jane Koppelman, December 12, 1999.

[5] Gloria James, director of school-based health centers for the Delaware Department of Health and Social Services, Division of Public Health, telephone interview conducted by Julia Lear, January 20, 2000.

[6] Lynn Howard, aide to Governor Carper, telephone interview conducted by Jane Koppelman, February 15, 2000.

[7] Tom Carper, Governor of Delaware, telephone interview conducted by Jane Koppelman, November 23, 1999.

[8] Nancy Wagner, Connecticut Republican Assemblywoman, telephone interview conducted by Jane Koppelman, February 15, 2000.

[9] That same year, 23 states directed $9 million in MCH block grant dollars to the centers. Lear et al.1999.

[10] Unpublished data from Making the Grade, The George Washington University School of Public Health and Health Services, Washington, DC. May 2000.

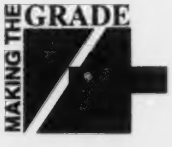
[11] This range of billing activity also depends on a center's billing sophistication as well as the numbers of Medicaid-enrolled children they serve.

[12] Unpublished data, 1998 National Census of School-Based Health Centers conducted by the National Assembly on School-Based Health Care, Washington, D.C.

[13] Internal Revenue Service Manual Transmittal 7(10)69-38, March 27, 1992.

[14] Santelli, J., A. Kouzis, and S Newcomer. School-based health centers and adolescent use of primary care and hospital care. J Adolesc Health.19 (October, 1996): 267-275.

[15] D Kaplan et al., "Managed Care and School-Based Health Centers: Use of Health Services," Archives of Pediatrics and Adolescent Medicine, 152 (January, 1998): 25-33.



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